



# Medicaid—The Need for Reform

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Recent administration proposals to address the rising cost of Medicaid will do little to contain costs or truly reform the program. The primary issues are the large differences among state Medicaid programs in coverage and benefits and the programs high and rising costs. In this paper, we describe and develop several options for Medicaid reform that would expand coverage, provide fiscal relief to states, shift responsibility for some or all of the cost of dual eligibles to the federal government, and eliminate or restructure the disproportionate share programs. A number of other issues are addressed, including Medicaid cost containment and the federal matching rate structure. (JEL I10, I18)

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**R**eforming the Medicaid program has been a major focus of the Bush administration and the Congress. The Deficit Reduction Act has already put forth some major changes to Medicaid, and the Bush administration has also approved several Section 1115 waivers that significantly change the program. Secretary of Health and Human Services Michael Leavitt also established a commission to consider fundamental reforms.

The primary diagnosis of the problem with Medicaid is the program's high and rising costs. Thus, most of the recent reform initiatives attempt to deal with containing program spending. In this paper, we argue that these recent policy initiatives (increased cost sharing, flexibility in benefit/design, and premium assistance) will not have significant effects on program spending and are not real reform. But while we do not believe that these initiatives will accomplish much, we do believe Medicaid does need reform for several reasons. We discuss these reasons and then present four alternative options as well, as cost estimates, for each. We then

discuss a number of remaining issues that are outside of these options and cost estimates.<sup>1</sup>

It is important at the outset to note that the Medicaid program has provided great benefits to low-income Americans. The program provides insurance coverage to over 40 million Americans on a given day and to some 50+ million at any point during the year. Most of these would not have had coverage without Medicaid. As a result, the number of uninsured would have been much higher than the 45 million reported for 2005. Medicaid has been a major source of health care coverage for low-income pregnant women and children, and for the disabled. The program pays for about half of all births in the United States. It helps low-income elderly and disabled people pay for Medicare premiums and cost sharing. It is a major source of support for safety net hospitals and clinics. Finally, it is the backbone for the nation's long-term care system.

The proposals adopted by the Bush administration and the Congress in recent years are not likely

<sup>1</sup> This paper was excerpted from a larger version (Holahan and Weil, 2007).

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to have significant effects on program costs. The problem with Medicaid is often identified as one of moral hazard.<sup>2</sup> People face low costs at the point of service thus tend to overuse services. In addition, the program is accused of having a “Cadillac” benefit package—benefits far exceed those available to low-income working Americans.<sup>3</sup> The administration and Congress’s solution to these problems is to provide states with greater flexibility to impose more cost sharing and to limit benefit packages. These policies may reduce overall use of program services but could also do great harm by reducing use of services that are vitally needed by low-income populations. The recent proposals also ignore the fact that Medicaid in essence solves the rationing problem that cost sharing is designed to serve by keeping provider payment rates low, reducing access to providers, and thereby reducing utilization.

The real reason for spending growth in Medicaid is primarily due to two things: (i) enrollment growth that can be traced to the erosion of employer-sponsored insurance, particularly for low-wage workers, and increases in income inequality—both have meant that more people qualify for Medicaid under existing eligibility standards; and (ii) an increase in the incidence and recognition of disability resulting in a consistent (approximately) 3 percent increase in the number of disabled enrollees. Finally, the health care inflation that has plagued the entire health care system also affects Medicaid (Holahan and Ghosh, 2005, and Holahan and Cohen, 2006).

Recent research (Hadley and Holahan, 2003/2004) has shown that, on a risk-adjusted basis, Medicaid costs are not higher than for low-income people with private insurance (see Figure 1): Statistical studies that control for disability and the presence of chronic illness show that private coverage for the same population would be more costly. Spending would increase from \$719 to

\$795 for children and from \$3,145 to \$4,410 for adults (2001 dollars) if people on Medicaid were given private coverage, not including the likely increase in administrative costs. Furthermore, Medicaid costs have not been growing faster than private insurance (see Figure 2).

But while recent diagnoses and solutions do seem misguided, we do believe that Medicaid does need reform. We highlight four reasons.

First, Medicaid costs are a growing burden for states. Although Medicaid costs per enrollee are not high in comparison with costs in the private market, Medicaid enrollment growth coupled with medical care inflation is clearly forcing health care spending to increase faster than the rate of growth in state revenues.

Second, the variation among states in coverage and provider payment rates is extremely large and difficult to accept, given the large national stake in financing the program, i.e., at least half of the money in each state is federal dollars. Thus, we believe how these funds are used is a national concern and the variation that we observe is inconsistent with the best interest of the nation (Holahan, 2003, and Spillman, 2000).

Third, a related issue is that eligibility standards are extremely complicated, difficult to understand, and restrictive—that is, they exclude populations, including childless adults, that have very low incomes and are in need of better access to health care.

Finally, the creative financing arrangements that states have used over the last 15 years, while typically legal, have also led to a considerable amount of mistrust between the federal and state governments (Coughlin and Zuckerman, 2003, and Rousseau and Schneider, 2004). They have led to the transfer of funds to state governments with little or no state matching payments, a practice that is clearly inconsistent with the fundamental nature of the program.

## ALTERNATIVE OPTIONS

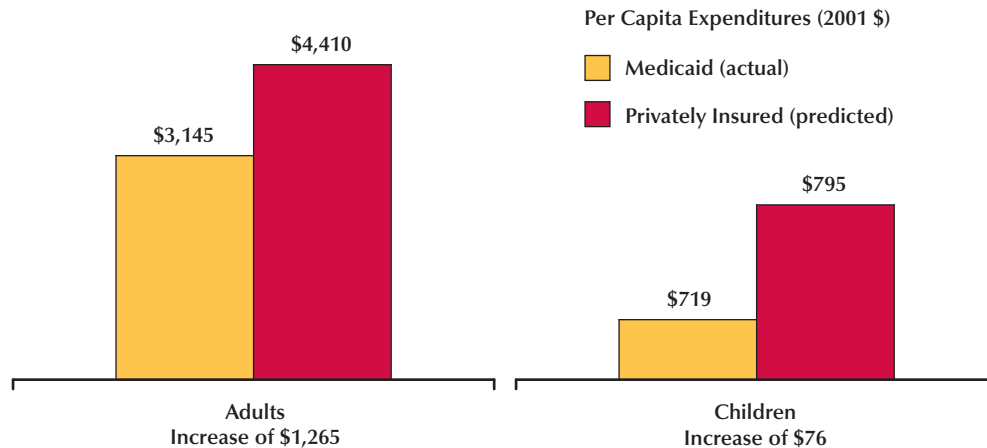
We propose four options that will address these problems. All have somewhat different objectives. All are designed to cost about the same amount to

<sup>2</sup> Although not specific to Medicaid, the general case for overuse as a concern is set forth in Council of Economic Advisors (2006) and Cannon (2005).

<sup>3</sup> References by political leaders to Medicaid as a Cadillac program are legion. For example, see the radio address by Tennessee Governor Phil Bredesen, June 11, 2005; <http://democraticgovernors.org/news/280> (accessed February 9, 2007).

**Figure 1**

**Medicaid Costs Are Not Higher Than Private Insurance on a Risk-Adjusted Basis**

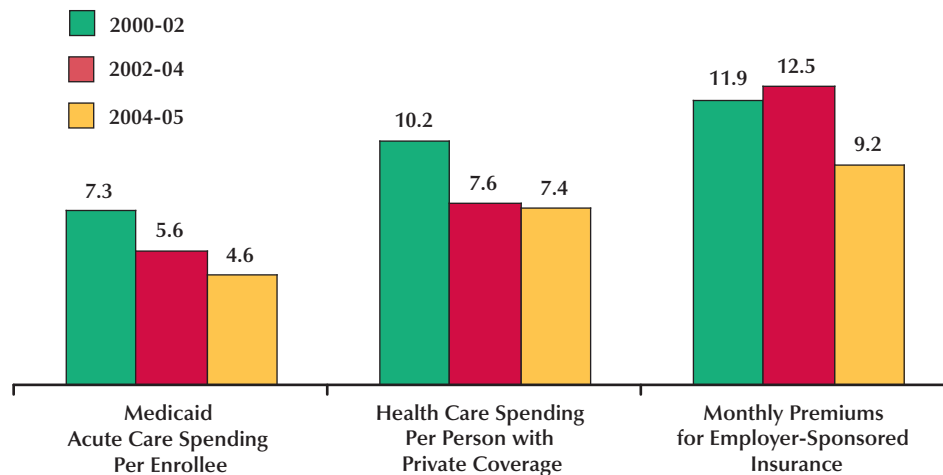


NOTE: All differences are statistically significant at the 5 percent level. "Adults" include ages 19 to 64. "Children" include ages 0 to 18.

SOURCE: Analysis of Medical Expenditure Panel Survey data from 1996, 1997, 1998, and 1999 are from Hadley and Holahan (2003/2004).

**Figure 2**

**Medicaid Costs Are Not Growing Faster Than Private Acute Care Services, 2000-05 (percent)**



SOURCE: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2006; and Ginsburg et al. (2006).

the federal government and to provide about the same savings to states. They each will increase costs to the federal government more than they provide savings to the states. The net additional cost is overwhelmingly due to the coverage expansions that are a part of each option. The key components of reform are as follows:

1. States would be required to increase coverage to certain income levels for parents and childless adults and be given the option to offer coverage to individuals at higher income levels. This would establish a uniform base of coverage across states and reduce the number of uninsured. It would provide a base to build upon with other policies such as tax credits or income-related subsidies as, for example, has occurred in Massachusetts.
2. Responsibility for some services or populations would shift wholly to the federal government and some would shift wholly back to the states. In general, this shifting would involve some or all of the care for “dual eligibles”—those eligible for both Medicare and Medicaid—who would become the responsibility of the federal government. This would provide fiscal relief to states and give the federal government a central role in managing these high-cost cases. With some care shifted back to states, system efficiency would potentially improve, which would offset for the federal government the costs of their new responsibilities.
3. Federal matching rates for selected populations or services would be increased, e.g., “adults,” “acute care,” or long-term care, depending on the option. This would provide fiscal relief to states and an incentive to expand coverage—by lowering the costs to do so. Also, this would allow states to avoid cutbacks in times of fiscal stress because the benefits from contractions would be less.
4. The Disproportionate Share Hospital (DSH) program would be ended or reformed to severely curtail the practices of increasing federal matching payments with no real state contribution. In the paper, we focus on

DSH payments, but the intent is to include all similar practices.

### **Option I**

The primary focus of this option is on expanding coverage for acute care services. It would provide a 30 percent enhanced match to cover all adults with incomes of up to 150 percent of the federal poverty level (FPL) and allow states to use the enhanced match to provide coverage to individuals at higher income levels. The State Children’s Health Insurance Program (SCHIP) would end, but Medicaid would be altered to have somewhat similar characteristics. There would be no enrollment caps, but there would be premiums and cost sharing for children of families with higher incomes, as in the current SCHIP program. Medicare premiums and cost sharing for acute care services for dual eligibles would become the responsibility of the federal government. The current “clawback” payments would be retained. (These are payments a state makes to the federal government for the state’s estimated share of drug payments they would have had to pay had there been no Medicare drug benefit.) This option would increase federal matching payments on acute care services by 30 percent. This would affect acute care services used by adults, children, and disabled populations who are not dual eligible. The matching rates for long-term care would be unchanged. The DSH program would be eliminated because there would be less of a need for this residual safety net as coverage expands, and any additional remaining needs would become a state responsibility.

### **Option II**

Option II also places a strong emphasis on coverage expansion and fiscal relief for states, but extends the financial help to spending for long-term care. Option II would mandate that coverage be extended to all adults to 150 percent FPL and provide a 15 percent enhanced match to do so. Federal matching payments for all services, both acute care and long-term care, would be increased by 15 percent; SCHIP would stay a separate program. Federal matching payments for Medicaid and SCHIP would be 15 percent above the current

level for Medicaid. This would end the distinction between SCHIP and Medicaid, where children of families with higher incomes receive higher federal payments through SCHIP. It would federalize acute care services for dual eligibles, including eliminating the clawback payment now made by states. Option II would also eliminate DSH for the reasons given above.

### **Option III**

Option III would focus more on long-term care because it assumes that the primary policy concern is the impact of an aging population on states. Option III would mandate coverage of all adults, but only to 100 percent FPL. There would be no change in current matching rates for acute care services. SCHIP would be unchanged and maintain the current higher federal matching payments. It would federalize acute care services for dual eligibles and eliminate the drug clawback. The major focus here would be an increase of 30 percent in federal matching payments for services for long-term care. This option would also restructure DSH. Because there is less of a coverage expansion than in other options, DSH payments would be maintained but redistributed so that the states would get the same amount per low-income person. This would deal with the current problem of poor distribution of funds: 10 states now get 71 percent of DSH payments, 5 states get more than \$1,000 per uninsured person and 16 states get less than \$100 per uninsured person.

### **Option IV**

Option IV would be the largest change in current policy. It would mandate coverage of all adults to 100 percent FPL but there would be no change in matching rates. SCHIP would be unchanged and keep the current 30 percent matching rate. The major focus would be to shift all costs of dual eligibles to the federal government, including costs for long-term care; responsibility for costs for long-term care for non-dual eligibles would shift back to the states. This option would also eliminate the prescription drug clawback payment. Finally, DSH payments would be restructured as described in Option III.

## **Policy Changes Common to All Options**

There are certain provisions that are common to all options. First, prescription drugs coverage would become a mandatory benefit. All states currently provide prescription drugs coverage, so this is not, in practice, much of a change. Second, there would be increased flexibility in the use of cost sharing above 150 percent FPL but not below. Third, there would be increased flexibility on mandatory benefits for adults but little or no change in benefits for children or the disabled. For example, benefits through the current Early Periodic Screening, Diagnosis, and Treatment Program would remain. Finally, there would be caps on enrollments in the new optional programs (i.e., programs beyond those mandated).

## **COVERAGE EXPANSIONS**

We estimate the impact of coverage expansion using a detailed spreadsheet model that begins with the baseline of current coverage. The U.S. population is organized by children, parents, and childless adults; by income; by current insurance arrangements; and by four geographic regions. We model current eligibility for public programs in great detail for each state. We then apply “take-up rates” (the probability of individuals “taking up” the newly available coverage) to each group based on the current research evidence (Selden, Banthin, and Cohen, 1998; Dubay, Haley, and Kenney, 2002a; Dubay, Holahan, and Cook, 2007; and Davidoff, Yemane, and Adams, 2005). We also rely on the extensive literature on the crowding out of private coverage by public expansions (Blumberg, Dubay, and Norton, 2000; Cutler and Gruber, 1996; Dubay, 1999; and Lo Sasso and Buchmueller, 2004). We base our estimates of Medicaid spending on the Medicaid Management Information System for 2002, adjusting forward for inflation using several different sources to obtain 2007 estimates.<sup>4</sup> Because those persons likely to come into the program through a coverage expansion are likely to be healthier than those in existing programs, we

<sup>4</sup> Congressional Budget Office, March 2006 baseline.



**Table 1****Estimated Cost of Expanding Coverage to 100 Percent and 150 Percent FPL**

	100 percent FPL	150 percent FPL
<b>Change in coverage (millions)</b>		
Medicaid	7,070	11,117
Employer	-924	-1,861
Nongroup	-967	-1,477
Uninsured	-5,167	-7,779
<b>Cost to government (2006 \$ billions)</b>	24.1	38.1
Regular matching rates		
Federal	14.0	22.2
State	10.0	15.9
30 percent higher match		
Federal	18.2	28.9
State	5.9	9.2

make an adjustment for the better health status of those new enrollees. We also assume a reduced benefit package for adults and make a downward adjustment (7.5 percent) to the cost of care for that population.

Table 1 shows the effect of the coverage expansions on Medicaid enrollment. An expansion to 100 percent FPL would increase Medicaid rolls by 7.1 million and to 150 percent FPL by 11.1 million. The majority of these new enrollees would be childless adults. The number of uninsured would fall by 5.2 million with an expansion to 100 percent FPL and by 7.8 million with an expansion to 150 percent FPL. The cost to the federal government would be \$24.1 billion and \$38.1 billion, respectively.

As shown in Table 2, each of the four options would increase federal spending by between \$41.1 and \$48.5 billion. At the same time, states would save between \$15.1 billion and \$22.6 billion. The net additional cost to the health care system would be between \$25.8 billion and \$29.7 billion. Option IV has the largest increase in federal spending and the greatest savings to states. Option I has the greatest net increase in cost to government as a whole.

The biggest impact on costs is the coverage expansion. For example, in Option I, the expansion to 150 percent FPL with a 30 percent enhanced match would increase costs to the federal govern-

**Table 2****Change in Spending (2006 \$ billions)**

Option	Federal	State	Net
I	44.8	-15.1	29.7
II	44.6	-15.6	29.0
III	41.1	-15.3	25.8
IV	48.5	-22.6	25.9

ment by \$28.9 billion and to states by \$9.2 billion (see Table 1). The changes in federal matching payments would shift a substantial amount of money to the federal government and save states a considerable amount as well.

After expanded coverage, the next biggest impact on cost would come from changes in policies affecting dual eligibles. The cost of having the federal government pick up Medicare premiums and cost sharing for acute care services and retaining the current policy on the drug clawback would increase federal costs by \$7.5 billion and reduce state spending by the same amount. Federalizing acute care for dual eligibles but eliminating the clawback would increase the federal costs by \$14.1 billion and save states the same amount. Shifting all of the costs of dual eligibles to the federal gov-

**Table 3****Impacts of Proposed Medicaid Reform Options by Region, 2006**

Option	Northeast		Midwest		South		West	
	Federal	State	Federal	State	Federal	State	Federal	State
I	21.1	-16.8	28.4	-12.6	35.8	-11.7	34.0	-8.8
II	22.5	-18.0	29.5	-14.7	33.7	-6.6	35.9	-12.8
III	23.4	-19.8	28.4	-13.9	29.4	-7.3	29.3	-7.9
IV	33.8	-30.7	34.8	-22.3	27.1	-3.3	36.3	-16.7

NOTE: Spending data were adjusted to 2006 using the CMS-64 and Congressional Budget Office projections (March 2006 baseline).

SOURCE: Author's calculations based on population information from the March 2005 Current Population Survey and spending data from the 2002 Medicaid Management Information System.

ernment would shift \$47.7 billion from the states to the federal government.

These policies would have different effects across regions. The coverage expansions would have the biggest impacts on the south because coverage levels are currently lower there. The increases in federal matching rates would help the northeast the most because Medicaid programs in that region tend to have broader coverage and richer benefits than elsewhere in the country. Federalizing spending for dual eligibles also benefits the northeast the most, again because of broad coverage and richer benefits, particularly in long-term care. Cuts in DSH payments would hurt the northeast and the south the most. DSH restructuring would have an adverse effect on the northeast but would benefit all other regions, although not all states within those regions.

Table 3 shows these effects. For the northeast, Option IV offers the greatest increase in federal spending and greatest savings to the states. Because the northeast spends proportionately more on dual eligibles than other regions, it would benefit the most from shifting dual eligibles to the federal government. In contrast, the south is better off under Option I because of the increase in federal payments it would receive for broad coverage expansion. However, it would gain less from the increased matching rates because it spends less on those services currently.

## OTHER ISSUES

There are a number of other issues that are important for Medicaid reform.

### Cost Containment

Cost containment efforts historically have relied on controls over provider payment rates and increased use of managed care. Recent initiatives are attempting to introduce more cost sharing and benefit flexibility. As noted, these initiatives are likely to have relatively small effects. Rather, we believe that cost containment should be focused on the beneficiaries with the highest cost. At present, 7.5 percent of Medicaid beneficiaries account for two-thirds of Medicaid spending (Sommers and Cohen, 2006). There is a need for a large federal investment in both Medicaid and Medicare case management and care-coordination programs (Lieberman et al., 2003; and Thorpe and Howard, 2006). There is a need for changes in payment approaches to provide incentives for physicians to coordinate and manage the care of patients with multiple chronic conditions and to expand Medicaid managed care (with beneficiary protections) to more of the disabled (Anderson, 2005; Berenson and Horvath, 2003; Wagner, Austin, and Von Korff, 1996; and Medicare Payment Advisory Commission, 2006, Chap. 2). This is new territory to be sure, but clearly this is where the money is and where the focus of cost containment for spend-

ing on particularly low-income populations should be focused.

### ***Provider Payment Rates***

We believe the provider payment rates should be improved. This would improve the image of the program among providers as well as increase physician participation rates. Setting minimum standards and rates could become the responsibility of the Medicare Payment Advisory Commission. Medicaid payment rates could gradually be increased over time, i.e., to a minimum of 90 percent of Medicare rates.

### ***“Creative” Financing***

Creative financing, including all practices that bring in federal monies without real state or local matching rates, should be eliminated. We have focused on DSH in the discussion above, but there are a number of other similar arrangements such as upper payment limit programs, school-based clinic programs, and targeted case management (Allen, 2005; and Coughlin, Bruen, and King, 2004). These programs added at least \$13 billion to federal outlays in 2005 with unknown state matching contributions. The federal government should enforce current rules designed to reduce or eliminate all such practices (Schwartz et al., 2006).

### ***Medicaid Participation***

There should be an effort to increase participation rates in Medicaid. In general, participation rates of those eligible for Medicaid are slightly above 50 percent. Some states have much higher participation rates (Dubay, Haley, and Kenney, 2002b). There should be a combination of federal promotion and advertising as well as federal standards for outreach, income verification, and recertification. Higher participation rates would increase Medicaid enrollment and spending but also lower the number of uninsured, reducing the need for many government programs that support safety net providers.

### ***Eligibility for Long-Term Care***

Long-term care has generally not been discussed in the options presented above. Two areas,

however, are important. While it is important to deter deceptive practices (e.g., transferring assets to become eligible for Medicaid), deterrence is not likely to result in large budgetary savings (O’Brien, 2005). However, under the current requirements, people must “spend down” (i.e., spend large amounts of money) before becoming eligible for Medicaid. Thus, there is a need to permit people to retain somewhat higher levels of assets and income. The second issue is the extreme unevenness in the coverage of home and community-based services for impaired elderly and disabled people. Efforts should be made to permit states to expand coverage of home and community-based services in general and to people with higher income levels.

### ***Change the Federal Matching Fund Formula***

The federal matching formula should be reformed (Miller and Schneider, 2004). The current system now recognizes differences in incomes. It needs to be restructured to recognize differences in income distribution as well. For example, two states with the same income level could have very different proportions of their population in poverty and thus different needs for federal assistance. Centering the matching rate on income per person in poverty would end up shifting dollars to states with a more skewed distribution of income. If some of the other changes in matching rates and shifts in responsibility to the federal government that have been discussed in this paper were adopted, then all states would come out as winners, but some more than others. There is a need to increase matching rates with rising unemployment on a timely basis.

## **CONCLUSIONS**

We have identified the following problems with Medicaid: large interstate variation in coverage, costs that are increasingly a burden to states, complex eligibility rules, and creative state financing. To address these problems, we propose to expand and provide a more uniform base of coverage and reduce the number of uninsured. These uniform standards would be easier for the states and federal



government to build upon, with further reforms designed to reduce the number of uninsured Americans. We would also shift more of the financial responsibility for Medicaid to the federal government and provide fiscal relief to states. We would give the federal government greater responsibility for managing the care of high-cost patients, which would also provide a strong incentive for the federal government to invest in learning how to manage these high-cost cases. Finally, our proposals would severely restrain the financial manipulations that are now too great a part of the Medicaid program.

The nation is now undertaking a new discussion over universal coverage. We believe Medicaid reform has to be part of that discussion.

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